FROM THE OVERSEAS JOURNALS

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Militant juniors

The young psychiatrists in training are not the only disgruntled section of the British medical profession at the moment. The junior hospital doctors as a whole have been on the warpath, and some of their talk sounds very like what I have been hearing from trade unionists all my life. "Exploitation", "cheap labour", "the 48 hour week", "overtime pay" — all the old phrases are there. To what extent the agitation is justified depends mostly on the age group of those who listen to their claims.

The Chairman of the Junior Hospital Doctors' Section of what has now become the medical trade union (as a part of a larger trade union of scientific and technical staff) sets out his views on a new deal for his colleagues in the *Lancet* for 4 September (page 541). He lists the grievances — poor pay, poor quarters, ill-defined duties so that the junior has to do a lot of odd jobs (whenever in history did he not have to do them?), long hours, and haphazard training. This last complaint is probably the one that most cries out for redress; as he says, few of the so-called teachers have had any training themselves for either training or teaching.

"Most contracts for junior hospital doctors at present are simply blank cheques for the hospital authorities to use junior staff as they wish", says Dr. Noone and the only reason the juniors have stood for this so long is that they have a misplaced (*sic*) sense of "my profession right or wrong", and go in fear of the wrath of their seniors. As someone said of the seniors, "they've got us by the testimonials".

To rescue these poor slaves, a new section of the Medical Practitioners' Union for junior doctors has emerged and drafted a model contract as the centrepiece of a campaign to mobilize junior hospital medical staff in the U.K.

This contract includes demands for a job specification with limitations on work (do I see demarcation disputes looming up, on the lines that are wrecking the British shipbuilding industry?), adequate accommodation (agreed; the powers that be have not realized that young doctors now marry), an arbitration procedure for a disputed dismissal, study leave guaranteed (agreed), an attempt at continuity of employment in a systematic training program (agreed), 192 hours of duty in any 4-week period plus overtime payments and compulsory breaks in duty, as for airline pilots (but unfortunately disease and injury do not work to a time schedule and there is a shortage of medical personnel, so what to do — let some patients go untreated?).

The writer of the article sees the campaign as really part of a larger campaign to improve the National Health Service. If this turns out to be true, it will be the first time in recent history that a campaign to improve the lot of public servants (which is what our British doctors now are) has been of value to the public — or so it must seem to a public with worsening transport, postal services and all the rest. So let us hope that the M.P.U. succeeds where others fail.

Incidentally, there is an amusing exchange of comments in *Community Medicine* for 8 October. The Medical Practitioners' Union, seeking new fields to conquer, has not only taken up the cudgels in favour of the oppressed junior doctors but also on behalf of what are now known as community physicians (what you would still call medical health officers) and laments that it was not consulted in a recent move by the Royal College of Physicians of the U.K. to start a new organization for these worthy but somewhat undervalued people.

The editor of *Community Medicine,* instead of grasping the hand of the benevolent trade union, comments that medical officers of health are traditionally nonpolitical since they have to serve communities run by both conservative and labour elements, and that they are quite content to be represented by the British Medical Association, thank you. He then remarks rather tartly that he thinks there are enough bodies already representing the professional and material interests of the public health services.

Medical manpower

The more arrogant among us are inclined to think that the phrase "medical manpower shortages" applies mainly to doctors, but this is not always so. A medical care system can break down just as well if there are not enough garbage collectors working in a hospital. The Danish system was threatened some time ago, simply because the big hospitals had not enough trained housekeepers — it is useless to admit patients to beds when there is nobody to take charge of the bed linen.

Recently there has been a continuing crisis in Norway's main hospital, the Rikshospital in Oslo, because there are not enough nurses. The waiting list grows ever longer while wards operate in the surgical departments with two-thirds of beds empty. Meanwhile the few nurses available are grossly overworked. Late in October patients from all over the country demonstrated outside the Parliament building about this state of affairs. One of the reasons for this absurd situation in an advanced welfare state is that the budgetary allotment for the hospital calls for a number of personnel below modern needs, according to the hospital director. The bureaucrats have not realized that a modern hospital has a much bigger turnover of patients, and all this means more work by more people to get them in and out. The waiting list may not look too bad, but it is alleged that doctors are just not troubling to refer elective cases to the Rikshospital because they know the bed situation is hopeless.

Meanwhile across the border the Swedes are having difficulties with recruitment to some of the specialties. In *Lakartidningen* for 13 October, Nilsson records grave shortages in recruitment to radiology, ophthalmology and otology.

A welfare state is a nice concept, but to hand out the welfare means recruiting people and motivating them to function. This seems to be causing problems to our Scandinavian friends — problems that may affect Canada soon.

Some malpractice cases

The Annual Reports of the two British medical protective agencies are always full of interest. The report of the Medical Protection Society has recently appeared, and this time the medical section (there is a dental section as well) focuses on medical negligence and eye injuries.

Keith Lyle, author of this part of the report, complains that diagnosis of the presence of an intraocular foreign body is missed far too often. He notes that there may or may not be a history of pain in the eye after an incident at work, usually when the patient or his mate has been hitting a solid substance with a hammer; vision may not be impaired and there may be no external abnormality. If there is the slightest doubt, x-ray examination of the orbit is mandatory. A flying particle of metal from a hammer or chisel is usually very small and likely to pierce the cornea or sclera without leaving a trace and embed itself in an intraocular structure. Unless it hits the lens or causes bleeding, vision may seem normal. Use of a mydriatic and examination of the fundus for local edema or swelling is necessary, and a slit lamp microscope may reveal the track of the object.

If a fragment of iron is left in the eye it will eventually lead to siderosis with deposition of iron compounds on various tissues and their subsequent degeneration. Copper and brass may in addition cause a slow panophthalmitis. The report adds several case histories to show how legal actions indefensible in court may arise from the above situation.

The Society repeats its warning of last year about failure to x-ray wounds for fragments of glass; it has had to compensate two more patients because of neglect of this warning.

Illegible handwriting led to a couple of misadventures. In the first, a surgeon's semilegible notes led his resident to perform the wrong operation on a woman with pain in the wrist; in the second a pharmacist supplied chlorpropamide instead of chloramphenicol because he misread the doctor's handwriting and the patient died.

One instructive case arose after a surgeon performed vasectomy. The man was advised to abstain from intercourse for one month, but 2½ months after the operation his wife became pregnant and a sperm count showed 36,000 spermatozoa per ml. It was suggested that this might be a case of duplicate vas, but this seemed like a weak defence. The Society then attempted to assess the damage sustained through the pregnancy and finally settled for around 2500 dollars. The report questions whether the birth of a child can in law be considered a loss to the family concerned. But it recommends that full contraceptive technique be advised until a clearance can be given, that portions of both vasa deferentia be sent for section, that only two negative sperm counts at an interval of a week taken three months after operation be considered acceptable evidence of sterility, and that advice be definite and recorded in the surgeon's notes.

Obesity and smoking habits

All those of you who have given up smoking are aware that the penalty is a gain in weight unless you are very vigilant and strong willed indeed. Now two observers from South Wales report on data about this phenomenon, and — guess what? — for once your clinical impression and the popular folklore were right. People who do not smoke *are* fatter. It is such a relief to find that at least one cherished popular belief was correct that one is apt to overlook the details of the report.

Khosla and Lowe (*Br Med J* 2 October 1971, p. 10) present observations on the relation between smoking and obesity in over 10,000 men employed at a steel works in South Wales, dividing the men into those who had never smoked, those who had given up smoking, and those who smoked. They note that the desirable weight for height is attained in their population at about 20 years, and thereafter weight and obesity rise steeply until about 35 years of age. At this point the weight of smokers tends to level off while the nonsmokers get fatter until the age of 50. In middle age, men who have never smoked are on average 13 lb. heavier than smokers — but both groups are obese, for the nonsmokers are still over 15 lb. above the desirable weight for height. One curious paradox is that heavy smokers are heavier than moderate ones, perhaps because they also drink more beer. When a man gives up smoking at age 45-54 years, he gains about 10 lb. in the next two years and gets to the level of the nonsmokers in 8 years.

Now here is a problem for the social reformer. The Office of Health Economics suggested in 1969 that being 10 lb. overweight carried a greater health risk than smoking 25 cigarettes a day; this is probably incorrect but there is no doubt that smoking and obesity are both hazards. What we need to evaluate is their relative danger; it seems a pity to save your life by giving up smoking only to lose it through gluttony.